



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# **RPMS EHR Remote Support and Configuration – Albuquerque Area Small Sites Cohort Agenda**

June 11<sup>th</sup> – 14<sup>th</sup>, 2012

IHS Office of Information Technology (OIT)

Albuquerque, New Mexico

&

Ysleta Del Sur Pueblo Community Health Center, Pueblo of Isleta Health  
Center, Jemez Health Center, Denver Indian Health & Family Services &  
Pine Hill Health Center

## **Background**

On February 17, 2009, President Barack H. Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA provides incentives to encourage hospitals and office-based physicians to adopt EHRs and other health information technology (HIT) solutions that reduce costs by improving quality, safety, and efficiency. ARRA contains numerous technology and privacy provisions with aggressive timelines for completion. Many of these ARRA milestones are related to the standards and work of the Healthcare Information Technology Standards Panel.

### ***Health Information Technology for Economic and Clinical Health Act***

The Health Information Technology for Economic and Clinical Health Act (HITECH) is a focal point of ARRA and represents an investment of more than \$19 billion towards healthcare information technology (IT)-related initiatives. The \$19 billion dedicated to HITECH is divided into two portions: (a) \$17 billion toward a Medicare/Medicaid incentive reimbursement program for both healthcare organizations and providers who can demonstrate “meaningful use” of an approved EHR; and (b) \$2 billion available to providers located in qualifying rural areas, providers serving underserved urban communities, and Indian tribes. Meaningful use of an approved EHR will be required in order for providers to qualify for, and continue to receive, incentives.

### ***Incentive Payments***

ARRA will provide incentive payments through Medicare and Medicaid reimbursement systems to encourage providers and hospitals to adopt EHRs and HIT. Hospitals that demonstrate meaningful use of certified EHRs and other HIT may be eligible for between \$2 million and \$8 million. Incentive payments are triggered when a provider or hospital demonstrates that it has become a “meaningful EHR user.” The highest incentive payments will be granted to hospitals that adopt EHR technology in the years 2011, 2012, or 2013. Reduced incentive payments are granted to hospitals that adopt EHR technology in the years 2014 or 2015, while no incentive payments are granted to hospitals that adopt EHR technology after 2015. Providers and hospitals that fail to meet this time limit will be subject to penalties in the form of reduced Medicare reimbursement payments beginning in 2017.

### ***Meaningful Use***

Meaningful Use (MU) is a term used by CMS to ensure that providers and hospitals that have adopted certified EHR are using the technology to further the goals of information exchange among health care professionals. EPs (eligible providers) and EHs (eligible hospitals) will achieve meaningful use if they: (a) demonstrate use of certified EHR technology in a meaningful manner, (b) demonstrate the certified EHR technology provides for electronic exchange of health information to improve quality of care, and (c) use certified EHR technology to submit information on clinical quality and other measures.

Achieving meaningful use will be accomplished in three stages. Stage 1 will begin in 2011, Stage 2 will begin in 2013, and Stage 3 will begin in 2015. The criteria for achieving meaningful use will increase with each stage and will build upon the prior stage. Medicare and/or Medicaid incentives are available to providers and hospitals who become meaningful users of certified EHR technology, with the maximum incentives being given to EPs and hospitals that become meaningful users in Stage 1. Hospitals may be eligible for both Medicare and Medicaid incentives but EPs must choose between the two incentive programs.

For the 2011 Medicare incentives, EPs must report on three core measures and a set of specialty measures which vary depending on the EP’s specialty. Eligible hospitals must report on a set of 35 measures that includes emergency department, stroke, and VTE, among other measures. Reporting of clinical quality measures in 2011 will be accomplished by attestation. Beginning in 2012 for both Medicare and Medicaid incentives, EPs and hospitals must submit information electronically on both the health IT functionality and clinical quality measures.

### ***Meaningful Use Standards and Measures***

As required to achieve MU, eligible hospitals (EH) and eligible providers (EP) must report their performance on two types of measures: (a) functional and interoperability measures and (b) clinical quality measures.

The functional and interoperability measures aim to improve quality, safety, efficiency and reduce health disparities. Reporting periods for measures include (a) a continuous 90 day period for the first year and (b) the entire year for all other years. There are 25 measures for EPs: eight measures require a “Yes” or “No” answer while 17 measures require both a numerator and denominator. Eligible Hospitals require 23 measures: ten measures requiring a “Yes” or “No” answer and 13 requiring a numerator and denominator.

**Table 1: Summary Overview of Meaningful Use Core Set Objectives**

<b>Core Set</b>	<b>Objectives to be achieved by all Eligible Professionals, Hospital, and Critical Access Hospitals in order to qualify for incentive payments</b>
Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in case of hospitals, date and preliminary cause of death in the event of mortality).	More than 50% of patient’s demographic data recorded as structured data.
Record Vital Signs and chart changes (height, weight, blood pressure, body mass index, growth charts for children).	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data.
Maintain up-to-date problem list of current and active diagnoses.	More than 80% of patients have at least one entry recorded as structured data.
Maintain active medication list.	More than 80% of patients have at least one entry recorded as structured data.
Maintain active medication allergy list.	More than 80% of patients have at least one entry recorded as structured data.
Record smoking status for patients age 13 or older.	More than 50% of patients age 13 or older have smoking status recorded as structured data.
For individual professionals, provide patients with clinical summaries of each office visit; for hospitals, provide an electronic copy of hospital discharge instructions upon request.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. More than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided it.
Upon request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures).	More than 50% of requesting patients receive electronic copy within 3 business days.
Generate and transmit permissible prescriptions electronically (does not apply to hospitals).	More than 40% are transmitted electronically using certified EHR technology.
Computer provider order entry (CPOE) for medication orders.	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE.
Implement drug-drug and drug-allergy interaction checks.	Functionality is enabled for these checks for the entire reporting period.

<b>Core Set</b>	<b>Objectives to be achieved by all Eligible Professionals, Hospital, and Critical Access Hospitals in order to qualify for incentive payments</b>
Implement one clinical decision support rule and the ability to track compliance with that rule.	One clinical decision support rule implemented.
Implement systems to protect privacy and security of patient data in the EHR.	Conduct or review security risk analysis, implement security updates as necessary, and correct identified security deficiencies.
Report clinical quality measures to CMS or states.	For 2011, provide aggregate numerator and denominator through attestation. For 2012, electronically submit measures.

**Table 2: Summary Overview of Menu Set Meaningful Use Objectives**

<b>Menu Set</b>	<b>Additional objectives: eligible professionals, hospitals, and critical access hospitals may choose to defer any five from the menu set.</b>
Implement drug formulary checks.	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period.
Incorporate clinical laboratory test results in EHRs as structured data.	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one listing of patients with a specific condition.
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate.	More than 10% of patients are provided patient specific education resources.
Perform medication reconciliation between care settings.	Medication reconciliation is performed for more than 50% of transitions of care.
Provide summary of care record for patients referred or transitioned to another provider or setting.	Summary of care record is provided for more than 50% of patient transitions or referrals.
Submit electronic immunization data to immunization registry or immunization information systems.	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions).
Submit electronic data on reportable laboratory results to public health agencies.	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data).
<b>Additional Menu Set for Eligible Professionals</b>	
Send reminders to patients (per patient preference) for preventive and follow-up care.	More than 20% of patients age 65 or older or age 5 or younger are sent appropriate reminders.
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, and medication allergies).	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR.

## **Purpose of Remote Configuration and Support**

The purpose of this virtual RPMS EHR Consultative Visit is to prepare the Indian Health Service facility for implementing *Stage 1 Meaningful Use* criteria within their Outpatient setting.

## **Agenda**      **9:00 AM – 4:00 PM (1 hour lunch @ 12:00) MDT**

### **Day One:**

- Workflow and Diagrams
- Identification of Equipment Needs
- Roles & Responsibilities

### **Day Two:**

- Institution File
- Medical Center Division File
- Location File
- Patient Registration Workflow & Site Parameters
- Clinic Scheduling Workflow & Parameters
- User Management & Provider Setup

### **Day Three:**

- PCC Master Control File
- Coding Queue
- PCC Data Entry Site Parameters
- Immunization Package Site Parameters
- BLR Master Control File
- PLAL Report
- PCC Management Reports
- Provider Practice Reports
- Meaningful Use Reports
- CRS Reports
- Adverse Reaction Tracking (PCC)

### **Day Four:**

- POC Test Configuration
  - Hemoglobin A1C
  - Glucose
  - Estimated Average Glucose
  - Strep Screen
  - Urine Pregnancy
  - Dipstick UA

*Note: Agenda is subject to change due to needs of participants*

## **Area and EHR Consultants Biographies**

### **Philip Taylor, RN**

#### **Contractor (Medsphere)**

Phil is a Clinical Consultant for Medsphere Systems Corporation. Phil has been a Registered Nurse for over 30 years. He holds a degree in Nursing from Vincennes University and a B.A. in Classical Studies from Indiana University. Phil provided clinical application support to VA Medical center staff using the VistA electronic medical record system for over 12 years prior to joining Medsphere. Phil's clinical history was primarily in Psychiatric Nursing. Currently Phil's primary responsibilities are providing training support (such as Basic CAC School and EHR for Inpatient) and configuration/setup support to OpenVista/EHR installations.

### **CAPT (ret) David R. Taylor, MHS, RPh, PA-C, RN, NCPS**

#### **EHR Training and Deployment Manager**

#### **IHS Office of Information Technology**

CAPT (ret) David Taylor is a retired Commissioned Officer in the United States Public Health Service and is a certified physician assistant, registered pharmacist, and registered nurse. Captain (ret) Taylor holds more than 33 years of public health, clinical, and clinic-administrative experience in the Indian Health Service (IHS). During his commission, he has served as a pharmacist, physician assistant, quality manager, risk manager, and compliance officer for the Pine Ridge, South Dakota and Cherokee, North Carolina Indian Hospitals. He has also served as an HIV/AIDS/STD consultant, performance improvement consultant, pharmacy consultant, and diabetes clinical consultant for the Nashville Area Indian Health Service. At this time, he is the EHR Deployment Manager for the IHS Office of Information Technology and has been charged with both training and deployment of the Electronic Health Record throughout the entire Indian Health Care system. David Taylor has been awarded the PHS Meritorious Service Medal (MSM) in recognition for his accomplishments in the EHR arena.

### **CDR Wil Darwin, Jr., PharmD, CDE, NCPS**

Commander Wil Darwin is a Commissioned Officer in the United States Public Health Service and has been in the Indian Health Service since 1997. Commander Darwin completed his Doctor of Pharmacy at the University of New Mexico Health Science Center, School of Pharmacy. He is now stationed at the Acoma-Canoncito-Laguna Service Unit, Indian Health Service in Acoma, New Mexico. His current duties include Directorship of the Patient Support Care Services, Chief of Pharmacy Operations and also the lead Clinical Application Coordinator (CAC) for RPMS-EHR. His pharmacy clinical responsibilities are various clinical outcomes-based programs such as Anticoagulation Clinic, Immunization Pharmacy Driven Clinic, Diabetes Type 2, Hyperlipidemia, Asthma, and Hypertension disease state management services. Commander Darwin is also assigned to the Albuquerque Area Office as the acting Area Pharmacy Consultant and the Inpatient EHR CAC.

